

**EXPRESS SCRIPTS**  
**APPLICATION FOR SECOND LEVEL APPEAL: PRESCRIPTION DRUG COVERAGE**

**THIS APPLICATION FOR SECOND LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING YOUR PRESCRIPTION DRUG COVERAGE (MEDICAL NECESSITY OF MEDICATIONS, PRIOR AUTHORIZATION, EXCLUDED MEDICATIONS, ATTEMPTING TO REFILL MEDICATIONS TOO EARLY, ETC.)**

**IMPORTANT NOTICE:**

***YOU MUST COMPLETE THIS FORM AND PROVIDE ALL REQUESTED INFORMATION.***

**In order for the administrator to carefully review the facts and give every consideration to your issue, you must include all of the information requested below. Failure to provide all pertinent documentation may affect the outcome of this review. It is essential that you keep copies of all documentation you submit in support of your Second Level Appeal. The information you submit is provided at your own expense. The records submitted will be retained by the administrator. You must file this Second Level Appeal within 180 days of the date you receive notice of First Level Appeal determination from the Prescription Benefit Administrator or Claim Processor; otherwise, your right to further appeal is waived.**

**Your appeal must include the following:**

- Complete, date, and sign this APPLICATION FOR SECOND LEVEL APPEAL (both employee and patient, other than a minor, must sign this Application)
- Attach a copy of the Prescription Benefit Administrator's or Claim Processor's First Level Appeal determination letter
- Explain, in detail, why you believe your issue in question should be approved by the administrator
- Include all information and documents that you believe support your appeal
- Attach all Explanation of Benefit Statements (EOBs) you have received relating to this issue
- Include copies of all correspondence that you sent to or you received from the Prescription Benefit Administrator or Claim Processor
- Include any published literature and/or documentation, if applicable, related to the medication at issue
- Include copies of all your prescription receipts for the claim at issue
- Include documentation of any telephone conversations you had with the Prescription Benefit Administrator
- If your issue of appeal involves medical necessity for your medication, prior authorization for your medication, or if your medication is being used for purposes other than those approved by the US Food and Drug Administration, please include complete clinical records from the prescribing physician and from any other physicians with whom you've consulted regarding this particular medication
- If you experienced any extenuating circumstances that you believe have a bearing on your appeal, include complete and specific details of such circumstances, and provide documentation to support the existence of such circumstances, and how they affected your case
- Other \_\_\_\_\_

***Your failure to provide all pertinent documents may affect the outcome of your appeal review.***

**INCLUDE ALL FACTS AND CIRCUMSTANCES THAT YOU WANT TO BE CONSIDERED WHEN YOUR SECOND LEVEL APPEAL IS REVIEWED. AFTER THE ADMINISTRATOR ADVERSE RENDERED A DECISION ON YOUR APPEAL, ADDITIONAL OR NEW INFORMATION WILL NOT BE CONSIDERED. THEREFORE, IT IS IMPERATIVE THAT YOU INCLUDE ANY AND ALL PERTINENT INFORMATION WHEN YOUR SECOND LEVEL APPEAL IS SUBMITTED.**

**EMPLOYEE'S SECOND LEVEL APPEAL:**

The benefit(s) to which I believe I am entitled is/are as follows (describe the type of benefit and the circumstances involving your case, being as specific as you can). Please refer to the specific Plan provision from your **Summary Plan Description**, which you believe entitles you to the benefit(s) you are claiming (attach additional pages if needed):

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TOTAL AMOUNT OF APPEAL (IF KNOWN) \$ \_\_\_\_\_

**PLEASE PRINT, SIGN, AND DATE THE FOLLOWING:**

<b>EE Name:</b>	<b>Benefit ID#:</b>
<b>EE#:</b>	<b>EE Signature:</b>
<b>SS#:</b>	<b>Patient Signature:</b>
<b>Address:</b>	<b>Date:</b>
<b>Address:</b>	<b>Home Phone:</b>
<b>City:</b>	<b>Work Phone:</b>
<b>State:</b>	<b>Cell Phone:</b>
<b>Zip:</b>	<b>Email:</b>

**ESI ADDRESS**

<b>CLINICAL APPEAL REQUESTS</b>	<b>ADMINISTRATIVE APPEAL REQUESTS</b>
<b>Attn: ESI Clinical Appeals Department</b>	<b>Attn: ESI Administrative Appeals Department</b>
<b>P.O. Box 66588</b>	<b>P.O. Box 66587</b>
<b>St. Louis, MO 63166-6588</b>	<b>St. Louis, MO 63166-6587</b>
<b>(F) 877.852.4070</b>	<b>(F) 877.328.9660</b>
<b>(P) 800.282.2881</b>	<b>(P) 800.282.2881</b>